State Facility Bed Use for Children and Adolescents: Report to the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Child and Family Behavioral Health Policy and Planning Committee

August, 2006

In January 2006, based on recommendations from the Inspector General on the current use of public mental health beds for children and adolescents, the DMHMRSAS met with staff from the Commonwealth Center for Children and Adolescents (CCCA), the Adolescent Unit at Southwestern Virginia Mental Health Institute (SWVMHI), the Office of Child and Family Services at the DMHMRSAS, and several other staff from DMHMRSAS. Staff in this meeting reviewed the recommendations of the Inspector General and developed a set of questions to respond to the recommendations (see below). To answer the questions, it was determined that a larger committee be formed consisting of various stakeholders involved in providing and/or receiving services from the state facilities. The DMHMRSAS asked that the Child and Family Behavioral Health Policy and Planning Committee activate the Child and Adolescent Special Populations Workgroup to develop a report that answers the questions developed by the staff who attended the Central Office meeting.

Members of the Child and Adolescent Special Populations Workgroup formed an ad hoc "State Facility Bed Use Subcommittee" co-chaired by Sandy Bryant, Director of Child and Family Services at Central Virginia Community Services Board in Lynchburg, Virginia and Don Roe, Director of Clinical Program Services at the Commonwealth Center for Children and Adolescents in Staunton, Virginia. (See Appendix A for a complete list of participants.) The subcommittee met four times from February 2006 to May 2006 with the specific task of addressing the following questions generated by the DMHMRSAS to respond to the recommendations of the Inspector General:

1. Who are the state facilities serving now? Why?
2. How well are they served and how do we know?
3. What indicators do we have that demonstrate that we are serving children and families in the intended way?
4. Who should the facilities be serving in 5 years? In 10 years?
5. Describe the future plan for the system of care for children and adolescents in the Commonwealth and the role of the state facilities in that system.
6. What priority community-based services are needed to accomplish the plan?
7. What role should the private sector play in the desired system of care? Acute? Residential?
8. How will we strategically engage the private sector to continue to play the needed role in the system of care?
9. What are indicators that demonstrate that the public and private providers are being used in the way we need them to be used?
10. Describe the plan to transition existing public beds for children and adolescents from current services to the desired future services.

This report will address responses from the subcommittee to each question. Recommendations for use of current beds and options for the future will be included.

Who are the state facilities serving now? Why?

Prior to 1999, the DMHMRSAS operated five child and adolescent facilities or units across the state totaling about 180 beds: the child and adolescent unit at Eastern State Hospital in Williamsburg (20 beds for children and 20 beds for adolescents), the Adolescent Unit at Central State Hospital in Petersburg (28 beds), the Virginia Treatment Center for Children in Richmond (36 beds), the DeJarnette Center in Staunton (60 beds), and the adolescent unit at SWVMHI in Marion (16 beds). Currently, the DMHMRSAS operates only two child and adolescent programs totaling 64 beds: the free-standing 48-bed CCCA (formerly DeJarnette Center) in Staunton and the 16-bed Adolescent Unit at SWVMHI in Marion.

General Demographic Information

Prevalence

The National Institute of Mental Health and the U.S. Center for Mental Health Services (CMHS) estimate that each year between 9% and 13% (3.5 million to 4 million) of children and adolescents ages 9 to 17 experience emotional or behavioral disorders (CMHS, 1997). The prevalence of the diagnosis of major depressive disorder among all children ages 9 to 17 is estimated at five percent. Suicide rates per 100,000 for youth for the year 2002 were as follows: 1.23 for 10- to 14-year olds and 7.44 for 15- to 19-year olds. Boys are more likely to commit suicide although girls are twice as likely to attempt suicide. Preliminary studies of the CMHS' Comprehensive Community Mental Health Services for Children Program suggest that at least one in five children may have a mental health problem. According to the study, without help, these mental health problems lead to a variety of additional problems including school failure, family discord, alcohol and other drug use, violence, or suicide. According to the Comprehensive State Plan 2002-2008 (DMHMRSAS, 2001), of the approximately 885,411 children between the ages of 0 and 17 in Virginia, it is estimated that as high as 97,395 (11%) children have serious emotional disturbance. Approximately 60,000 (7%) children have serious emotional or behavioral disorders with extreme impairment. It is estimated that approximately 5000 children with serious emotional or behavioral disorders receive some type of residential care annually.

Bed Use Data

Demographic data from FY 2000 through FY 2005 for the Adolescent Unit at SWVMHI include the following: total number of admissions—1447 (males—726, females—721); average age at admission for males was 15.7 and for females was 15.5; average length-of-stay was 13.3 days while the median was 8.0 days; legal status at admission—TDO (680), involuntary (289), voluntary (303), and court-ordered (175).

Data from CCCA for the same time period shows the following: total admissions—2799 (males—1696, females—1103); average age at admission was 13.3 for males and 14.2 for females; average length-of-stay—28.3 days and median length-of-stay was 20.0; legal

status at admission—TDO (522), involuntary (606), voluntary (953), court-ordered treatment (128), 10-day evaluation (589), and other (1—*restoration evaluation*).

Service Area

SWVMHI Adolescent Unit serves adolescents 13 years and older and their families residing in HPR 3 including the following CSBs: Blue Ridge Behavioral Health; Cumberland Mountain CSB; Danville-Pittsylvania CSB; Dickenson County Behavioral Health Services; Highlands CSB; Mount Rogers CSB; New River Valley CSB; Piedmont CSB; and Planning District One Behavioral Health Services. Children under the age of 13 in HPR III are served at CCCA.

CCCA serves children and adolescents ages 4 through 17 from every CSB in Virginia (HPRs I, II, III, IV, and V) except adolescents 13 years and older from HPR III who are served by SWVMHI. With a large service area, CCCA may admit children and adolescents from every area of Virginia. However, the Center primarily serves the following CSBs (the following comes from FY 2006 admissions data from highest to lowest for CSBs that admitted five or more children to the Center): Richmond Behavioral Health; Fairfax-Falls Church; Rappahannock Area; Region Ten; Northwestern; Henrico; Valley; Central Virginia; Prince William; Loudoun; Rappahannock-Rapidan; Harrisonburg-Rockingham; Norfolk; District 19; Arlington; Virginia Beach; Alexandria; Chesterfield; Crossroads; Hampton-Newport News; New River Valley; Blue Ridge; Middle Peninsula-Northern Neck; Chesapeake; Mount Rogers; and, Rockbridge (see Appendix B). All other CSBs referred at least one child who was admitted to the Center in FY 06, except Dickenson County CSB which had no admissions to the Center that fiscal year. Over the six-year period from FY2000 to FY2005, the top ten CSB users of CCCA services were (in order) Fairfax/Falls Church, Region Ten, Rappahannock Area, Richmond, Valley, Prince William, Northwestern, Blue Ridge, Central Virginia, and Henrico. During the same period, the CSBs using CCCA the least include Goochland-Powhatan, Portsmouth, Dickenson, Danville-Pittsylvania, Western Tidewater, Colonial, Middle Peninsula-Northern Neck, Hanover, Chesapeake, and Mount Rogers.

Diagnostic Data

SWVMHI Adolescent Unit serves adolescents with a range of diagnoses. Predominant diagnoses include disruptive behavior disorders (45%), adjustment disorders (21%), mood disorders (15%), psychotic disorders (10%), Substance use disorders (5%), and other (4%).

CCCA also serves children and adolescents with a wide range of diagnoses. Data indicate that the primary DSM-IV-TR categories include major depressive disorder and other depressive disorders, bipolar disorder, schizophrenia and psychotic disorders, disruptive behaviors disorders, substance use disorders, anxiety disorders, adjustment disorders, pervasive developmental disorders including autism spectrum disorders, and mental retardation. Children with substance use disorders and developmental disorders generally are co-morbid with other primary diagnoses. CCCA, like SWVMHI Adolescent Unit, does not admit children or adolescents solely on the basis of substance

use or developmental disorders. From FY 2000 through FY 2005, primary diagnoses of children admitted included: 37% major depression; 17% disruptive behavior disorders; 14% adjustment disorders; 10% anxiety disorders (including PTSD); 22% other, including bipolar, schizophrenia, and developmental disorders (autism spectrum, Tourette's, and mental retardation), eating disorders, and substance abuse disorders. Most children and adolescents admitted with major depressive disorders are seriously self-injurious and/or severely acting out in the community. Co-occurring MH/SA disorders are found in more than 65% of adolescents served. All children who are admitted to CCCA have a primary mental health diagnosis and most also have significant behavior problems which poses threats to families, schools, detention centers, and/or the communities at large.

How well are they served and how do we know?

In order to discuss the quality of services at the state facilities, we feel it is necessary to outline the services provided and to include the mission and values promoted by the two facilities. In this section, we will include comments from the VACSB Child and Family Council regarding satisfaction with services at SWVMHI and CCCA.

SWVMHI Program Overview

SWVMHI Adolescent Unit is comprised of the following staff: 1 psychiatrist; 1 psychologist; 1 program director; 2 social workers; 7 nurses; and 20 psychiatric aides. The goal of the unit is to provide services to stabilize young people and return them back to the community. The milieu is centered on helping youth develop appropriate expectations. Services provided to youth include assessment, medication management, family therapy, dynamic recreation therapy, and academic instruction. Both activities therapy and nursing staff lead therapy groups on the unit. SWVMHI serves as a training ground for university students/interns but rarely on the adolescent unit. SA services are handled individually; SWVMHI does have one SA Education Group. Forty percent (40%) of adolescents admitted to the unit have co-occurring MH/SA diagnoses.

The adolescent unit is located with other patient care areas in the Bagley building at SWVMHI. The following is a brief overview of the entire facility which was built in 1990 on the grounds of the older facility. Besides the adolescent unit, the institute also includes 172 total beds with 50 community prep adult beds, 6 infirmary beds, 20 intermediate care geriatric beds, 20 acute geriatric, and 60 acute admission beds

The mission of SWVMHI is "We promote mental health in Southwestern Virginia by assisting people in their recovery" (new 2006 statement). To accomplish this mission the facility staff value recovery, effective communication, trust with accountability, individual initiative that meets needs through hard work and creativity, teamwork, honesty with compassion, leadership at all levels, and honoring day-to-day tasks and interaction that collectively promote recovery.

CCCA Program Overview

CCCA is a free-standing child and adolescent inpatient facility located near Western State Hospital. The current building is 10 years old and was designed to be state-of-the-

art for children's inpatient psychiatric services. The staff is comprised of the following disciplines: 4 child and adolescent psychiatrists; 5 PhD clinical psychologists; 9 social workers including two LCSWs; 16 registered nurses (12 with associate degrees, 1 diploma nurse, 1 BSN, 1 MSN-CNS Nurse Practitioner, and 1 MS degree); 65 direct care mental health counselors and supervisors (many with BAs and MAs in human service fields); and, 4 activities therapists (including a board-certified music therapist, certified recreation therapists, and masters-degreed counselors).

The Center provides a full array of psychiatric services including: 1) individual, group, family, behavioral, and activities therapies; 2) nursing and physical health care services; 3) child and parent/guardian education; 4) psychological testing; 5) social work services; 6) pharmacological therapy; and 7) education services. The Center uses both evidence-based and promising practices as part of its array of treatment services including cognitive behavioral therapy, social skills training, applied behavior analysis, and pharmacologic interventions to name a few (Commission on Youth, 2005). All therapeutic interventions are strengths-based and are provided from a trauma-informed perspective.

CCCA, in its affiliation with the University of Virginia serves as a training facility for students in all psychiatric fields including child and adolescent psychiatry child fellows, general psychiatry residents, senior medical students, clinical psychology interns, Master's level counseling students, and nursing students (both undergraduate and graduate). Students from other colleges and universities including both graduate and undergraduates from James Madison University, Eastern Mennonite University, Blue Ridge Community College, Radford University, Mary Baldwin College, and Virginia Commonwealth University represent the following disciplines: undergraduate psychology; nursing; graduate counseling; recreation therapy; healthcare administration; and, social work (both undergraduate and graduate).

Over the past year, the staff of CCCA has created new vision, mission, and values statements. The draft statements follow:

Vision: Our vision is for a system of care in Virginia that empowers children and families needing behavioral health services to choose from a wide variety of high quality options in partnership with competent service providers in each community.

Mission:

1) To provide high quality acute psychiatric evaluation, crisis stabilization, and intensive short-term treatment that empowers children and their families to make developmentally appropriate choices and that strengthens children's hope, resilience, and self-esteem.
2) To participate in building statewide capacity in behavioral healthcare services by providing training opportunities for mental health and human service providers and students in partnership with colleges, universities, and community agencies throughout central and western Virginia.
3) To participate in relevant research activities that advance knowledge of children's behavioral health care treatment in mental health, substance abuse, mental retardation and co-occurring disorders.

We value:

- Treating people with dignity and respect
- Personal privacy and confidentiality for all children and families
- Child-centered, family-focused, and community-based treatment
- Empowering families and children to make decisions
- Interdisciplinary planning processes that include children and their families
- Least restrictive interventions including reducing and eliminating the of use of seclusion and restraint
- Helping children develop and maintain meaningful relationships in the family, school, and community
- Trauma-informed care perspectives
- Strengths-based approaches with children, families, and one another
- Developing a competent and diverse workforce
- Evidenced-based and promising practices
- Therapeutic environments that foster normal growth and development
- A continuum of care that includes the safety net of public acute inpatient services
- Efficient use of resources

Feedback from Parents and CSBs Regarding Quality of Services at SWVMHI and CCCA

Predominately, parents respond very positively to the services their children receive in the state facilities. Satisfaction rates are typically well above 90%. Some comments parents have made about services at CCCA include: "Our experience with CCCA has been very beneficial. The staff is wonderful!" "My opinion/input was used and helpful." "...the social worker did an excellent job of filling me in on progress and treatment that was already in place. She kept us updated and involved." "My child could not have been placed in a better place. Services were superb." "My family and I appreciate CCCA's work with our son. When interacting with my family, CCCA staff was caring and professional. Our questions and concerns regarding our son's care always received attention." "I was very impressed with the staff and the doctor." "This staff is awesome. You guys have a hard job. Thank you all. You all 'Rock!'" "We were always treated with respect and kept up-to-date about how our daughter was doing. All questions were answered." "The entire staff is to be commended for the high quality of care for my son, support for our family, and knowledge and practical application of all aspects of his circumstances and illness. This placement at CCCA was probably the best thing that ever happened to him. The psychologist is always there for any questions, etc. He was great to work with. (Child's name) was able to do well in this program and had wonderful people to care for him." "Everything was explained well." "Staff takes a hands-on approach to helping the patients."

Parents involved in this State Facility Bed Use Subcommittee and other statewide committees contributed much to the discussion of need for a safety net for the most difficult to serve children. One family indicated that their daughter had been sent from private facility to private facility with no consistent course for treatment. Their daughter's behavior was so extreme that most facilities refused to accept her. After she was admitted to CCCA, the parents felt a connectedness with the staff who worked

intensively with their daughter and who were able to work with the family to develop with the CSB an excellent plan for continued care.

VACSB Feedback on Current Services—Winter 2006
On March 3, at the VACSB Child and Family Council meeting, a post discussion following a survey by email was held. The first question in the survey was "Has there been an increase in child referrals (ages under 18) this fiscal year?" 80% of the CSB's reported increase in referrals. Second question was "Has there been an increase in acute hospitalizations?" 70% of the CSB's reported an increase.

Consensus of the Council members at the meeting was state acute bed capacity is needed. Available data point to continued future need. Reduction in child state beds would result in a loss of the only current safety net for acute hospitalization for children in Virginia. 100% of the CSB's responded yes to the question that state bed hospitalizations were necessary due to private sector not having the willingness or the capacity to treat children for whom they were seeking acute beds—refusal for admissions from the private sector usually was due to the severe behaviors or the complexity of needs of child. Also, many children admitted to private acute hospitalization or private residential beds were transferred ultimately to state hospital due to inability to manage behavior on private unit or insurance had run out but child was still in need of acute care. Southwest Virginia CSB's reported less availability of private beds and one southwest CSB stated there were no other acute bed options other than the two state hospitals for children.)

Indicators for Service Effectiveness
Some key indicators that a psychiatric inpatient program is "doing what it is intended to do" include the following: recidivism; parent and child satisfaction; improvement in the quality of life; reduction of symptoms; and reintegration into the community and the family. Of these indicators, the state facilities currently track two—recidivism and satisfaction with services. The majority of families and children respond positively to services received at the two facilities. Mostly, they state how much the services provided have helped their children and have opened new avenues for continued work in their respective communities.

Whether children return to the facility post discharge is an indicator that speaks to the success of treatment intervention and discharge planning on the parts of both the facility and the CSB. Another important indicator is the availability of child and adolescent behavioral health services in each community. The general readmission rate for SWVMHI (all readmissions, not just those readmitted within 30 days) was 16%. CCCA maintains a database that looks at readmissions within 30 days of discharge—the average rate of readmissions for FY06 was 8.9% which falls below accepted thresholds.

What indicators do we have that demonstrate that we are serving children and families in the intended way?

CCCA and SWVMHI Adolescent Unit are public facilities operated by the Virginia DMHMRSAS. They are both licensed by the Office of Licensure and follow the

"Standards for Interdepartmental Regulation of Children's Residential Facilities" (22 VAC 42-10 et seq., July 2000). They follow the DMHMRSAS statewide "Rules and Regulations to Assure the Rights of Individuals receiving Services from Providers of Mental Health, Mental Retardation, and Substance Abuse Services" (12 VAC 35-115 et seq., 2001). Both facilities are accredited by the Joint Commission on the Accreditation of Healthcare Organizations and comply with the Virginia Department of Medical Assistance Services requirements as outlined in its "Virginia Medicaid Provider Manual for Psychiatric Services" (2003). The quality of each program can be attested by high levels of compliance to all of these standards and regulations. By meeting and exceeding these standards, each facility meets the state and national benchmarks for providing quality psychiatric services to children and adolescents.

Both the Commonwealth Center and the SWVMHI Adolescent Unit function as part of the network of mental health and substance abuse services in Virginia provided in conjunction with area community services boards, their respective community mental health centers, and other private behavioral healthcare providers. Most admissions to these facilities are prescreened through the community services board located in the area in which the child resides. Both voluntary and involuntary admissions are accepted pursuant to the criteria in the "Psychiatric Treatment of Minors Act" in the Code of Virginia, §16.1. A primary or secondary diagnosis of mental illness is required as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV). The state facilities do not provide outpatient programs but do provide outreach and support services for discharged clients as needed in close coordination with families, community mental health providers, and other community agencies.

The goal for each child and adolescent state facility/unit is to serve the acute care, crisis stabilization, and short term treatment needs of children and adolescents referred for services—to be the public safety net for the most difficult to serve and most complicated children and adolescents. In this capacity, both facilities try to provide intensive services in a short length-of-stay time period. This safety net is a critical part of the continuum of mental health services used by all communities in Virginia. Providing this type of acute care in the public sector is essential at this time because the number of private facilities providing acute care inpatient psychiatric services has declined over the past several years and continues to decline. One reason for the decline is the lack of adequate reimbursement rates for these services. However, the private providers have continued to build residential treatment services for Virginia's child and adolescent population because reimbursement is available at a rate that attracts this type of service. Because of these issues, the role now played by state child and adolescent facilities is critical to the network of services needed for the most difficult to serve children and adolescents requiring short term inpatient acute care psychiatry.

Involvement of families and community representatives is a hallmark of each facility's commitment to a child-centered, family-driven, and community-based system of care. From the point of admission to the point of discharge, parents and communities are involved in every aspect of care planning. All families are invited and encouraged to attend treatment planning meetings. These meetings can take place in person, via

telephone conference call, and using video conferencing technology at the choice of the family. CSBs have responsibility for discharge planning for each child. As such, representatives are required to participate in every aspect of care planning in order to support the family in discharge disposition. These processes at both facilities create collaborative and supportive working relationships. Communication between the CSBs and the both of the state facilities serving children and adolescents is almost universally excellent from the feedback received from CSBs over the years.

Both facilities serve as safety nets for the acute mental health needs of children across Virginia—particularly for nonmandated children who, in many localities, otherwise have no services. In this role, it is important for each facility to have available beds to serve the emergent needs of children. Providing acute short-term intensive care is necessary in order to assure availability of emergency inpatient beds. This involves providing intensive high quality interventions with the goal of decreased lengths-of-stay. Virginia has only a limited number of acute care psychiatric beds in the private sector and all of the current sixty-four public facility beds are required to serve this need. Both public facilities must also serve the needs of those children with autism and mental retardation who also have severe behavioral disorders and/or mental illness. This population is very difficult to serve and many private facilities are unable to provide the levels of interventions needed for these children. Both of the state programs serve other children who are less likely to be served by private program or who are unable to be served in community-based public programs. The many patients at both facilities had concurrent involvement in the juvenile justice system or court services in localities. Many children have criminal histories and some are complicated by the presence of co-occurring mental health and substance use disorders. Those with mental retardation and mental illness combined are some of the most dangerous and difficult to place children in the state. In a recent study, CCCA was shown to have high numbers of children with criminal and substance use histories and high numbers of children having mental illness within their families.

Who should the facilities be serving in 5 years? In 10 years?

Predicting future needs for child and adolescent public psychiatric beds is not an easy task. However, if we use history as a predictor of the future, we will see that both CCCA and SWVMHI will continue to be the safety net for acute inpatient services in Virginia. What may change this outcome will be determined by how much community-based funding will be appropriated over the next several years to:

- build community systems of care for all children with behavioral health problems;
- develop workforce capacity to operate such systems; and,
- develop private/public partnerships to complete the array of services need in all communities.

It is expected that Virginia's population will increase over the next ten years with a concomitant increase in the number of children. Increased numbers of children will result in increased community and state bed needs for the 5 to 10% of the population of children who will require intensive mental health services. We are reminded that 24% of

the population of Virginia is under the age of 18. Yet, only 14% of healthcare funds are spent on children. Importantly, only 7% of MH expenditures go to children (Landers, 2001). Among children with serious emotional disturbance (SED) the following are reported (Report, 2004):

- One in five children have a diagnosable mental health disorder (U.S. Department of Health and Human Services, Report of the Surgeon General, 1999)
- One in 10 children has a serious emotional disturbance (Burns, et al., 1995)
- 13% of preschool children in the US have mental health problems (Squires & Nickel, 2003)
- 11% have a mental health condition causing significant functional impairment (Glied & Cuellar, 2003)
- Between 44,455 and 62,237 children and adolescents in Virginia suffer from extreme impairment due to serious emotional disturbance (DMHMRSAS, 2003)
- One third of children with a mental health disorder have been diagnosed with two or more disorders (CMHS, 1997)
- 66% of juvenile offenders have at least one diagnosable mental disorder (Teplin, et al., 2002)
- 94% of youth entering detention have a history of drug use (McClelland, et al., 2004)
- Every night, 2000 children in the US wait in detention for community mental health services (Seltzer, 2004)
- Children of parents with mental disorders and/or substance abuse disorders have a 50% to 250% greater risk of developing mental health and substance abuse problems (SAMHSA, 2004)
- Children who have mental health problems are 4 times more likely to use and be dependent on an illicit drug than children who do not have a problem (SAMHSA, 1999)
- In 2002, 9% of US children live with at least one parent who abused or was dependent on alcohol and/or illicit drugs (NHSDA, 2003)
- Mental health problems are two to four times more prevalent among children in poverty (Glied & Cuellar, 2003)

Current services for children and adolescents with SED:

- 80% of children with serious emotional disturbance do not receive mental health services (Burns, et al., 1995)
- 92% of children and adolescents with serious emotional disturbance are served by three or more agencies (Glied & Cuellar, 2003)
- Hundreds of Virginia's children needing behavioral health services remain on waiting lists at CSBs (Voices of Virginia's Children, 2004)
- Cross-agency coordination of care is difficult (Glied & Cuellar, 2003)

Children and adolescents with serious emotional disturbances are at increased risk of out-of-home placement due to the lack of adequate or consistent community-based services. These children often require intensive therapeutic interventions, parental support, medications, multiple agency involvement, inpatient hospitalizations, and residential

treatment to address their pervasive problems. Children and adolescents who also display aggressive and violent behaviors require even more intensive services. Children and adolescents with co-occurring disorders, especially autism spectrum disorder and mental retardation, are typically more difficult to serve and require intensive interventions that stretch the capabilities of most facilities. These populations are expected to grow over the coming years and will need increased services in the broad continuum of care including acute stabilization and short term interventions found currently in the state facilities.

Describe the future plan for the system of care for children and adolescents in the Commonwealth and the role of the state facilities in that system.

System of Care

All recent efforts of statewide groups looking at the mental health needs of children have focused on the Georgetown University model of a System of Care (Pires, 2002). No system of care is exactly like another. Each is based upon the needs and partnerships of the stakeholders within a local system working in tandem with public and private providers and with local and state agencies. Systems of care are developed around five important principles that include 1) child-centered, 2) family-driven, 3) strengths-based, 4) culturally competent, and 5) with interagency collaboration. The goal of systems of care is to develop evidenced-based and promising practices community programs for children having behavioral health problems and their families.

The subcommittee suggests that DMHMRSAS and Virginia continue to support building community programs that address the array of services needed to serve children and their families. The following items (excepted from the Report of the Child and Adolescents Special Populations Workgroup, 2004) include these important considerations:

- All children in need receive appropriate and timely services;
- There must be significant family and youth involvement at all levels of planning, decision-making, and service delivery;
- There must be interagency collaboration at state and local levels;
- There must be sufficient and flexible funding for services;
- There must be an adequate amount of services/treatments that are: evidence-based/promising and/or best practices; child-centered; family-driven; culturally-competent; strengths-based; and community-based;
- There will be sufficient funding for research on innovative interventions;
- There must be an adequate supply of qualified professionals;
- There must be seamless access, equity, and efficacy of services.

Virginia's current system of behavioral health services for children and adolescents has elements of systems of care because of the Comprehensive Services Act passed by the General Assembly in the mid-1990s. The CSA system has required collaboration/coordination for nearly ten years at the local and state level. CSA's values include many of the values of the system of care model and the DMHMRSAS the state

board policy on children's services (1986) reflects the values of the systems of care model. With the CSA, there is local flexibility in service provision and parts of the continuum of care are available in some communities.

However, even with the CSA, many communities lack basic services for children's mental health care and support. In order to have a system that really address the needs of children with behavioral health problems and their families, Virginia must address the following weaknesses in its current system (Report, 2004).

- Inadequate funding of behavioral health services for youth and their families;
- Children's services are fragmented across the state;
- The state legal code does not require the provision of behavioral health services for children and their families, which results in discontinuity in priorities across state agencies and localities;
- State agencies continue to be fragmented in their approaches to strengthen delivery of services to children and their families;
- Service provision is inconsistent and diverse across the 40 CSBs;
- The children's system of care in Virginia does not have a clear and consistent vision, identity, and set of priorities;
- Poor coordination among state and local agencies causes confusion for families, overlapping services, and increased cost to taxpayers;
- CSA does not sufficiently fund the needs of children with behavioral health disorders;
- Funding streams are not coordinated or sufficient;
- Children with behavioral health disorders who are involved in the juvenile justice system are not adequately served;
- Most youth with substance abuse disorders are not adequately served because substance abuse services are not sufficiently funded;
- MH/MR/SA services are not integrated with each other system wide;
- Although specific components of a comprehensive community-based System of Care have been identified, the extent of implementation varies significantly from community to community;
- There is insufficient funding for capacity building for community-based services;
- There is a lack of child and adolescent psychiatrists and other child-trained professionals at many CSBs;
- There is a lack of consensus among service providers regarding how, which, and at what levels children's behavioral health services should be delivered;
- Children and families who receive behavioral health services funded by different funding streams receive different or no services;
- Services for children with mental retardation and severe behavior disorders are insufficient.

What priority community-based services are needed to accomplish the plan?

A full array of services needs to be in place in each community in order for true success of children and families needing behavioral health services. Those community-based

services should include the following (extracted from the Report of the Child and Adolescent Special Populations Workgroup, 2004):

Community-based Services

Minimum standards

- Immediate access to appropriate and recommended services
- Use of evidence-based, best practices, or promising practices and/or creative ideas for new and innovative approaches to integrated service delivery
- Outpatient psychotherapy is provided only by trained, licensed, and specialized clinicians
- Outpatient counseling provided only by qualified and/or license-eligible clinicians
- Authorization and approval of clinical services for children must be conducted by independently licensed clinicians specializing in child and adolescent treatment

Minimum services

- Screening and referral
- Diagnostic evaluations
- 24/7 crisis intervention and stabilization services, including psychiatric services
- Mobile and field response
- Crisis intervention and stabilization services
- Case management (per Medicaid regulations)
- Care coordination includes:
  1) consumer choice
  2) case management
  3) utilization review
  4) single unified treatment plan
  5) interagency collaboration
- Outpatient psychotherapy (Mental Health, Mental Retardation, and Substance Abuse)
- Intensive in-home therapy provided by licensed clinicians
- Day treatment
- Access to acute inpatient hospitalization
- Child psychiatry and psychopharmacology services provided by a board certified child psychiatrist (telemedicine may be useful for monitoring but not for initial evaluation)
- Respite care (MH, MR, SA)
- Family support services
- Primary health screening provided by nurses
- Early Intervention-Part C
- Early Intervention-Mental Health

Enhanced Standards (desired)

- Single access point or any door access
- All psychiatric services provided in person

- Coordination of care for children with Axis III diagnoses (quarterly contacts at minimum)

Enhanced Services (desired)

- Shared single intake form
- Shared MIS system
- Brief partial hospitalization
- Treatment/therapeutic foster care
- Group Homes
- Early intervention with at-risk children
- Prevention services
- Wraparound services
- 24-hour hospitalization
- Residential Treatment

General Considerations for services:

- Community-based system should be designed to meet the behavioral health-related needs of individual children and families
- All children with behavioral health problems have access to services
- The locality will be responsible for arranging the provision of all behavioral health services in the continuum of care
- Local or regional collaboration exists between the major child-serving agencies
- Local CSBs will be the responsible agencies for the administration, funding, and care coordination of the demonstration program
- One treatment plan for family that ensures collaborative service delivery across all agencies
- The care coordinator is responsible to link the family to all necessary and appropriate services related to behavioral health needs across agencies
- Parent involvement and leadership in the development, decision-making, and evaluation structures and processes
- The system must deliver services to the parents, guardians, and primary caretakers of the child, which are necessary to ensure that the behavioral health care needs of the child are met
- A system of care reinforces starting in and transitioning to least-restrictive services
- Treatment planning decisions are made by licensed clinicians
- Must include all minimum services and should include one or more enhanced services
- Needs assessments for child and family

- Uniform family treatment plan developed and implemented by a multi-agency team chaired by the clinical care coordination
- No barriers for disability
- Access for persons to include transportation, child care, language, outreach services
- One door or any door access

What role should the private sector play in the desired system of care? Acute? Residential?

In March 2006, Kathryn Power, the Director of Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration, spoke on the issue of building public/private partnerships (Power, 2006). She stated that it is an urgent mission to propel the transformation of our national mental health system and she emphasized that community-based care is critical to the transformation vision. She also stated that effective acute inpatient care is an essential component of a transformed system of care.

The private & public sector must be involved at all levels of discussion in Virginia in order to establish an effective system of care for children and adolescents. Virginia needs to develop a collaborative, strategic mix of public and private services in all communities that are appropriate, practical, and desirable for the needs of its children and their families. Although the private sector provides treatment options for both acute and residential care, it has been difficult over the years to find an adequate number of private facilities that will provide services to the most difficult to serve children and adolescents in Virginia. Those children currently not being served adequately by many private providers (as identified by both this subcommittee and the VACSB Child & Family Council) include: 1) children with mental retardation and concomitant behavioral disorders; 2) children with co-occurring substance abuse diagnoses; 3) children with autism spectrum disorder or severe developmental disabilities; 4) children who set fires; 5) children who self-mutilate; 6) children who sexually offend; 7) children with serious emotional disturbance who are aggressive toward others; and, 8) children involved in the juvenile justice system. Some private providers offer a few of these services, but there are not enough services to adequately address the needs of the entire state.

The private providers currently in Virginia offer an array of residential treatment beds for children and adolescents. Reimbursement rates for residential services tend to be adequate to support the operations of private residential facilities. However, acute beds for children and adolescents are not as plentiful in Virginia. This is due in part to the low reimbursement rate for these services. More acute services are strongly recommended. However, private providers say that acute services are more costly, the state and federal regulations are steeper, and the reimbursement rate is low making it nearly impossible to sustain effective treatment over time. One recommendation of the report of the Child and Family Behavioral Health Policy and Planning Committee (2006) is to request a rate review from the Department of Medical Assistance Services to assess whether the current

rate provided for acute psychiatric treatment is adequate to meet the actual costs for those services.

Another important aspect of a partnership with private providers is communication and discharge planning. We suggest that state requirements that mandate facility/CSB involvement for developing less restrictive discharge planning must be mandated for private providers as well (possibly through the licensing standards that regulate children's residential services across the state. This will help to ensure that the same collaboration & resources to the children and their families currently existing within the state's public child and adolescent inpatient facilities will also be available in the private sector. Education, consultation, and defining standards of Virginia's system of care across all providers will be necessary so that there is shared vision, shared core values, and shared principles of care within the public-private partnerships established within the transformation process. Creative, evidence-based, local treatment and support options must be diligently explored prior to any residential placement. Under no circumstances should a locality utilize the residential option as a means to remove a child from a dysfunctional home as the primary reason for placement. While residential placement represents a mid to long-term, expensive treatment option within a continuum of care, it can be an appropriate option for certain children and should be available in Virginia.

How will we strategically engage the private sector to continue to play the needed role in the system of care?

There are many ways to involve private child behavioral health services providers in this process. For example, the DMHMRSAS might provide some "scholarships" for private providers to attend SA workshops offered the department as it does for state facilities and local CSBs. Private providers must be invited to participate in statewide committees, workgroups, and other collegial discussion of children's behavioral health needs. The state can assist private providers by encouraging DMAS to review current reimbursement rate for inpatient psychiatric services. The two current public child and adolescent facilities already develop and maintain relationships with private providers within their regions to develop cooperative and complimentary services for children. This should continue. The state should also build statewide incentives that encourage private providers to come to Virginia rather than having Virginia's children in need go to other states for costly residential behavioral health services.

What are indicators that demonstrate that the public and private providers are being used in the way we need them to be used?

Both private and public sector service providers must have a collaborative, shared vision for the provision of community based services which includes significant local development of alternatives to residential and hospitalization for children and adolescents. The child and adolescent outcomes that would result from an effective local system of care would be: 1) decrease in behavioral and emotional problems; 2) improvement in functioning; 3) improvement in school performance; 4) decrease in truancy/school absences; 5) decrease in out of home placements; 6) decrease in

residential placements; 7) decrease in juvenile justice & law enforcement involvement/contact; 8) positive satisfaction surveys from families. A positive indicator for improvement in this area would be the inclusion of private sector representation at local mental health policy and planning meetings. Strong regionally-based public/private partnerships will be the inevitable outcome of such collaborative efforts.

Through the public/private partnerships there will be a blending of services to meet the overall needs of the state. Public beds would continue to be the safety net for acute care needs of the most complicated children as determined by CSBs. Private providers would serve the local acute needs of children as a primary source for services and/or serve as the residential placement for children requiring long-term care and treatment.

Describe the plan to transition existing public beds for children and adolescents from current services to the desired future services.

The members of the subcommittee expressed concern that the current number of children's public beds should not be reduced at this time. Sixty-four beds are a minimally adequate number for a population of 7.1 million people, 27% of whom are children under the age of 19. As the population of Virginia grows over the next several years, there may be a need to add more beds to the system. Considerations must be made for regionalizing public acute service by creating 12 to 16 additional regional beds (e.g., in the Tidewater area and/or Northern Virginia), and/or developing new partnerships with private providers in those areas to serve the acute care needs of children typically referred to the public facilities.

The 2000-2002 Appropriation Act included language (Item 329-G) directing DMMRSAS in cooperation with other child stakeholders to develop an integrated policy and plan to provide and improve access to mental health, Mental Retardation and Substance Abuse Services for children, adolescents and their families. The department established a workgroup, which identified recommendations that included:

- Integrate services across disciplines and agencies
- Implement statewide training on child mental health issues
- Develop new services and address gaps in existing services
- Increase the number of board certified/eligible child and adolescent psychiatrists and trained clinical psychologists. One strategy identified was for CCCA and SWVMHI to have stipends established for child and adolescent psychiatry fellows and doctoral interns in clinical psychology to build Virginia capacity.

The DMHMRSAS 2004-2010 Comprehensive State Plan emphasizes the need to decrease Virginia's reliance on its state facilities for services that could be more appropriately provided in the community. To effectively address the special service and support needs of children we must include strategic planning to reduce out of community residential placements. A short-term acute stay is preferable to a long-term residential placement. The transformation of the system should be guided by a vision for a system of care for children would include extensive training and workforce capacity-building, increased evidenced-based and community-based treatment, and on-going outcome

evaluation and research. The state child hospitals expertise will be critical in the transformation of services in the next 10 years. Predicted periods where bed days will be low (e.g. during late summer) will provide opportunities for child state facilities to collaborate with CSBs for training, consultation, and outreach to local communities and local hospitals and treatment facilities.

The following are recommendations for consideration:

1. This committee recommends that SWVMHI Adolescent continue to serve the needs of adolescents in Region III by providing a full array of acute inpatient serves for adolescents age 13 and older.
2. This committee recommends several roles for CCCA:
   - First, that it continue to serve its safety net role as the freestanding public facility for all of Virginia's children and adolescents (except those in Region III);
   - Second, as more community-based services are developed, including regionally-based inpatient services, that CCCA would become a regional acute site serving its current high use CSBs (see Appendix B). At that time, a portion of the CCCA beds would be designated to serve the most difficult to serve dually diagnosed children and adolescents many of whom are currently sent out of state for care. (This, however, presupposes that adequate additional services are developed to address the projected increase state-wide demand for acute, emergency mental health services for children and adolescents);
   - Third, that CCCA be designated a public Center of Excellence in affiliation with the Child and Adolescent Psychiatry Division of the University of Virginia's Department of Psychiatric Medicine. The Center would play an active part in assisting with community-based planning for the most difficult to serve children and adolescents, coordinating staff training for workforce capacity building in children's behavioral health, and developing and assisting with research projects that contribute to the knowledge base of child and adolescent behavioral health in collaboration with other agencies such as the University of Virginia, Virginia Commonwealth University, and the Virginia Treatment Center for Children.
3. This committee recommends that the DMHMRSAS consider developing an acute inpatient service for adolescents age 13 and older located between Richmond and the Tidewater area to serve the needs of this region (i.e., a 12 to 16 bed acute inpatient service).
4. The committee also recommends that CCCA, with its child-trained clinical staff, would serve as a central point for training and consultation in collaboration with all other public inpatient services for children and adolescents and any other services requesting such consultation. This collaborative partnership with the satellite facilities and services would serve to improve clinical consultation and review across services, increase the knowledge, skills, and abilities of various disciplines serving children and adolescents in these services, and would facilitate consistent provision of high quality of care across the state facilities serving children and adolescents. CCCA would coordinate training and development

opportunities including advanced child- and adolescent-specific clinical training for various clinical disciplines, and would offer opportunities for leaders in the facilities to meet regularly to make recommendations for vision, mission, and direction for ensuring a model mental health system for Virginia's future generations of children and adolescents

References

Burns, B., Costello, E., Angold, A., Tweed, D., Stangl, D., Farmer, E., & Erkanli, A. (1995). Children's mental health use across service sectors. *Health Affairs*, 14(3), 147-159.

Center for Mental Health Services (1997). Children's and adolescent's mental health. Online Fact Sheet. Available at: www.mentalhealth.org/publications/allpubs/CA-0004/C&amh.htm.

Commission on Youth (2005). Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs, 2nd Edition. Virginia General Assembly. Richmond, BA.

Department of Mental Health, Mental Retardation, and Substance Abuse Services (2001). Comprehensive State Plan 2002-2008. Richmond, VA.

Department of Mental Health, Mental Retardation, and Substance Abuse Services (2003). Comprehensive State Plan 2004-2010. Richmond, VA.

Glied, S., & Cuellar, A. E. (2003). Trends and issues in child and adolescent mental health. *Health Affairs*, 22(5), 39-50.

Landers, S. (2001). Child support: Making sure kids are covered. amednews.com March 26. www.ama-assn.org/amednews/2001/03/26/gvsa0326.htm

McClelland, G. M., Teplin, L. A., & Abram, K. M. (2004). Detection and prevalence of substance use among juvenile detainees. *Office of Juvenile Justice and Delinquency Prevention Bulletin*, June.

Pires, S. A. (2002). *Building systems of care: A primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child development Center.

Report of the Child and Adolescent Special Populations Workgroup (2004). Department of Mental Health, Mental retardation, and Substance Abuse Services. Richmond, VA.

SAMHSA (1999). National household survey on drug abuse: Main findings 1997. Rockville, MD: Substance Abuse and Mental Health Administration.

SAMHSA (2004). National household survey on drug abuse: Main findings 2004. Rockville, MD: Substance Abuse and Mental Health Administration.

Squires, J., & Nickel, R. (2003). Never too soon: Identifying social-emotional problems in infants and toddlers. *Contemporary Pediatrics*, 3:117.

Seltzer, T. (2004). The unnecessary incarceration of children and youth who are awaiting community mental health treatment and supports. Testimony before the Committee on Governmental Affairs, US Senate, June 7.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59, 1133-1152.

Voices for Virginia's Children. (2004). Lack of adequate community-based services. Fact Sheet: Richmond, VA.

Appendix A

List of Participants in the State Facility Bed Use Subcommittee

Sandy Bryant, RNCS, LPC, Children and Family Services Director, Central Virginia CSB (Co-chair)
Don Roe, PhD, Clinical Program Services Director, CCCA, (Co-chair)
Cynthia McClaskey, PhD, Director SWVMHI
Joe Tuell, MSN, Director, CCCA
Stacie Fisher, MSN, Office of Quality Management, DMHMRSAS
Joyce Kube, Virginia Federation of Families
Sue Akers, MA, Program Director, Adolescent Unit, SWVMHI
Martha Kurgans, LCSW, Office of Child and Family Services, DMHMRSAS
Barbara Shue, MSW, Social Work Director, CCCA
Roger Burkett, MD, Chair of the Child Psychiatry Division, UVA
Clark Bates, MD, Medical Director, CCCA
Lloyd Tannenbaum, EdD, CentraHealth, Rivermont School
Kathy Wittig, Parent Representative, Ashland, VA
Bill Wittig, EdD, MSW, Parent Representative, Ashland, VA
Anna Csaky-Chase, MS, Director of Youth Services, Mt. Rogers CSB
Pete Cooper, PhD, Psychology Director, CCCA
Tim Dotson, Superintendent, Highlands Detention Center
T. Russell McGrady, PhD, Clinical Director, SWVMHI
Janet Lung, Office of Children Services, DMHMRSAS
Tim Smith, Superintendent, Shenandoah Valley Detention Center
Teri Sumey, MEd, Director of Education, CCCA
Shannon Foreman, Health Care Administration Student Intern, Mary Baldwin College
Le'Anne F. Bailey, Health Care Administration Student Intern, Mary Baldwin College

Report Writing Subcommittee
Sandy Bryant, RNCS, LPC, Children and Family Services Director, Central Virginia CSB (Co-chair)
Lloyd Tannenbaum, EdD, CentraHealth, Rivermont School
Don Roe, PhD, Clinical Program Services Director, CCCA, (Co-chair)
Sue Akers, MA, Program Director, Adolescent Unit, SWVMHI

Appendix B

Bed Use Maps (under separate cover)